CHAPTER 6

PROTECTING THE MEDICARE TRUST FUND

This chapter provides an overview regarding how the Medicare Trust Fund is protected.

The goal of the Medicare Integrity Program (MIP) is to pay it right – pay the right amount, to the right provider or supplier, for the right service, to the right beneficiary. Some of the MIP or payment safeguard activities that Medicare Contractors complete are:

- Data analysis;
- Medical review (MR);
- Anti-fraud; and
- Medicare Secondary Payer (MSP) (see Chapter 3 for information about MSP activities).

Data Analysis

Data analysis is an integrated, on-going component of MR and benefit integrity (BI) activities which involves:

- Collecting data from:
  - Historical data (e.g., review experience, denial data, provider billing problems, provider cost report data, provider statistical and reimbursement data, billing data, Common Working File, and data from other Federal sources such as Quality Improvement Organizations [QIO], Medicare Contractors, and Medicaid) and
  - Referrals from internal or external sources (e.g., provider audit, BI unit, beneficiary, and other complaints)
- Identifying potential errors; and
- Instituting ongoing monitoring and modification of data analysis program components.

Medical Review

The MR process includes the following:

- Reviewing claims appropriately submitted to Medicare Contractors when atypical billing patterns or particular kinds of problems (e.g., errors in billing a specific type of service) are identified. QIOs conduct reviews of Acute Care Inpatient Hospital Prospective Payment System Diagnosis Related Group and Long Term Care Hospital claims.

- Ensuring that MR activities are targeted at identified problem areas and that the corrective actions imposed are appropriate for the severity of the problem through Progressive Corrective Actions. Providers with identified problems submitting correct claims may be subject to three types of corrective actions:
    - Education about appropriate billing procedures (problems at all levels require education)
    - Prepayment review, which is when claims are subject to MR before payment of the claim can be authorized (a percentage of claims may be subject to this corrective action) and
    - Postpayment review, which occurs after the claim has been paid

- Validating claim errors through the use of probe reviews. Providers are notified when probe reviews are conducted, asked to provide medical documentation for the claim(s) in question, and notified of the results of the probe review. Probe reviews can either:
    - Examine 20 – 40 claims per provider for provider-specific problems or
    - Examine approximately 100 claims from multiple providers for widespread, larger problems such as a spike in billing for a specific procedure

- When a probe review verifies that an error exists, the following occurs:
    - The severity of the problem is classified as minor, moderate, or significant which is determined by the provider-specific error rate (number of claims paid in error), dollar amounts improperly paid, and past billing history
    - Overpayments are collected and
    - A determination is made as to what steps need to be taken to correct the problem

Submission of medical records is required in a small number of cases for prepayment, postpayment, and probe reviews. A review of the medical records confirms that the services furnished are reflected on the claim, coded correctly, and covered by Medicare. Most MR does not require the review of medical records. If medical records are requested, they must be submitted within the specified timeframe or the claim will be denied. In some instances, claim attachments will be reviewed (e.g., Certificates of Medical Necessity and patient history files).

Providers can create medical record documentation that assists the MR process by ensuring that:

- Documentation is provided, when requested, for every service selected for MR;
- Documentation demonstrates that the patient's condition warrants the type and amount of services furnished;
- Documentation is legible; and
- Each service is coded correctly.

Providers can assist in the MR process by:

- Becoming familiar with coverage requirements;
- Ensuring that office staff and billing vendors are familiar with claim filing rules;
- Comparing records and billed claims;
- Creating a patient educational awareness campaign that explains Medicare coverage limitations and medical necessity requirements; and
- Performing mock record audits to ensure that documentation reflects requirements outlined in Medicare coverage policies.

Coverage Determinations

There are two types of coverage policies that assist providers and suppliers in coding correctly and billing Medicare only for covered items and services.

1) National Coverage Determinations (NCD)

A NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare Contractors are required to follow NCDs. Prior to an NCD taking effect, the Centers for Medicare & Medicaid Services (CMS) must first issue a Manual Transmittal, ruling, or *Federal Register* Notice. If a NCD and a Local Coverage Determination (LCD) exist concurrently regarding the same coverage policy, the NCD takes precedence.

Formal requests for NCDs may be submitted at *www.cms.hhs.gov/center/coverage.asp* on the CMS website or in writing to:

CMS
Coverage and Analysis Group
7500 Security Boulevard (Mailstop C1-09-06)
Baltimore, MD 21244

When formal requests are accepted and posted, the public may submit evidence or other comments relevant to the request at *www.cms.hhs.gov/center/coverage.asp* on the CMS website for a period of 30 days in accordance with §522(b) of the Benefits Improvement and Protection Act of 2000.

Drafts of proposed decisions are posted at *www.cms.hhs.gov/center/coverage.asp* on the CMS website, at which time the public may comment for a period of 30 days. Comments are reviewed and a final decision memorandum, which includes a summary and responses to public comments, is issued no later than 60 days after the conclusion of the comment period.

2) LCDs (formerly known as Local Medical Review Policies)

In the absence of a specific NCD, local Medicare Contractors may make LCDs, which are coverage decisions made at their own discretion to provide guidance to the public and the medical community within a specified geographic area. LCDs outline coverage criteria, define medical necessity, provide codes that describe what is and is not covered when the codes are integral to the discussion of medical necessity, and provide references upon which a policy is based. CMS reviews LCDs to ensure that they do not conflict with NCDs. Providers and suppliers may submit requests for new or revised LCDs to Medicare Contractors. The LCD development process is open to the public and includes:

- Developing a draft;
- Making the draft available to the public; and
- Soliciting comments about the draft from the public, which can be electronically submitted on Medicare Contractor's websites.

NCDs and LCDs that may prevent access to items and services or have resulted in claim denials can be challenged by aggrieved parties (Medicare beneficiaries or the estate of Medicare beneficiaries) who:

- Are entitled to benefits under Part A, are enrolled in Part B, or both (including beneficiaries who are enrolled in fee-for-service Medicare and Medicare Advantage);
- Are in need of coverage for items or services that are denied based upon an applicable LCD or NCD, regardless of whether the items or services were received; and
- Have obtained documentation of the need for the items or services from his or her treating physician.

If a claim is denied by a Medicare Contractor based on a NCD or LCD, the beneficiary is notified about the denial and the reasons for the denial on the Medicare Summary Notice.

Information about NCDs is available in the National Coverage Determinations Manual (Publication 100-03) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Fraud and Abuse

CMS emphasizes early detection and prevention of fraud and abuse. An estimated 10 percent of Medicare costs are wrongly spent on incidences of fraud and abuse. Preventing and detecting fraud and abuse is a cooperative effort that involves:

- CMS;
- Beneficiaries;
- Medicare Contractors;
- Providers, suppliers, and other health care entities;
- State Medicaid Fraud Control Units;
- QIOs;
- Department of Health and Human Services Office of Inspector General (OIG);
- Department of Justice (DOJ), including the Federal Bureau of Investigation; and
- Other Federal law enforcement agencies.

The efforts of these groups can help deter health care fraud and abuse and protect beneficiaries from harm by:

- Identifying suspicious Medicare charges and activities;
- Investigating and punishing those who commit Medicare fraud and abuse; and
- Ensuring that money lost to fraud and abuse is returned to the Medicare Trust Fund.

Federal health care fraud generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a Federal health care program. Some examples of fraud are:

- Billing for services not furnished;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Violations of the physician self-referral ("Stark") prohibition;
- Using an incorrect or inappropriate Provider Identification Number (PIN) in order to be paid (e.g., using a deceased provider's PIN);
- Signing blank records or certification forms that are used by another entity to obtain Medicare payment;
- Selling, sharing, or purchasing Medicare Health Insurance Claim numbers in order to bill false claims to the Medicare Program;
- Offering incentives to Medicare patients that are not offered to other patients (e.g., routinely waiving or discounting Medicare deductibles, coinsurance, or copayments);
- Falsifying information on applications, medical records, billing statements, cost reports, or on any statement filed with the government;
- Using inappropriate procedure or diagnosis codes to misrepresent the medical necessity or coverage status of the services furnished; and
- Consistently using billing or revenue codes that describe more extensive services than those actually performed ("upcoding").

In general, program abuse, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicare Program. Many abusive practices are subsequently determined to be fraudulent. For example, if a provider or supplier ignores Medicare guidance, education efforts, warnings, or advice that abusive conduct is inappropriate and he or she continues to engage in the same or similar conduct, the conduct could be considered fraudulent.

Significant Medicare Fraud and Abuse Provisions

1) False Statements and Kickbacks, Bribes, and Rebates

Under 42 U.S.C. §1320a-7b(a), if an individual or entity is determined to have engaged in any following activities, he or she shall be guilty of a felony and upon conviction shall be fined a maximum of $50,000 per violation or imprisoned for up to five years per violation, or both:

- Purposefully involved in supplying false information on an application for a Medicare benefit or payment or for use in determining the right to any such benefit or payment;
- Knows about, but does not disclose, any event affecting the right to receive a benefit;
- Knowingly submitting a claim for physician services that were not rendered by a physician; or
- Supplies items or services and asks for, offers, or receives a kickback, bribe, or rebate.

2) Anti-Kickback Statute

The Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b), prohibits offering, soliciting, paying, or receiving remuneration for referrals for services that are paid in whole or in part by the Medicare Program. In addition, the statute prohibits offering, soliciting, paying, or receiving remuneration in return for purchasing, leasing, ordering, arranging for, or recommending the purchase, lease, or order of any goods, facility, item, or service for which payment may be made in whole or part by the Medicare Program. An arrangement will be deemed to not violate the Anti-Kickback Statute if it fully complies with the terms of a safe harbor issued by the OIG. Arrangements that do not fit within a safe harbor and thus do not qualify for automatic protection may or may not violate the Anti-Kickback Statute, depending on their facts.

3) Physician Self Referral (“Stark”) Statute

The Stark Statute, 42 U.S.C. §1395nn, prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Exceptions to the prohibition on self referrals can be found in the *Code of Federal Regulations (CFR)* at CFR 411.355-357. To access the *CFR*, visit *www.gpoaccess.gov/cfr/index.html* on the Web. The designated health services include the following:

- Clinical laboratory services;
- Physical therapy services;
- Occupational therapy services;
- Speech-language pathology services;
- Radiology and certain other imaging services such as magnetic resonance imaging and ultrasound;
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services and supplies;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

The chart below depicts some of the criminal statutes that the DOJ may invoke to pursue individuals or health care entities that have committed fraud and abuse.

Fraud and Abuse Statutes

18 U.S.C. §1347	Health care fraud
18 U.S.C. §669	Theft or embezzlement in connection with health care
18 U.S.C. §1035	False statements relating to health care
18 U.S.C. §1518	Obstruction of a Federal health care fraud investigation
18 U.S.C. §371	Conspiracy to commit fraud
18 U.S.C. §287	False claims
18 U.S.C. §1001	False statements
18 U.S.C. §§201, 666	Bribery
42 U.S.C. §§1320a - 7b	False statements, kickbacks
18 U.S.C. §§1956 - 57	Money laundering
18 U.S.C. §§1961 - 64	Racketeering Influenced and Corrupt Organizations Act
18 U.S.C. §1343	Wire fraud
18 U.S.C. §1341	Mail fraud

The DOJ or a private relator can also file a suit under the civil False Claims Act (31 U.S.C. §3729) to recover any Federal losses due to false claims as well as additional amounts in the form of penalties and fines.

Potential Legal Actions

It is a Federal crime to commit fraud against the U.S. government, including the Medicare Program. A provider, supplier, or health care organization that has been convicted of fraud may receive a significant fine, prison sentence, or be temporarily or permanently excluded from Medicare and other Federal health care programs. In some states, providers, suppliers, and health care organizations may also lose their licenses. Below is a discussion of some of the potential consequences of failure to comply with fraud and abuse laws.

Investigations

A Program Safeguard Contractor or Medicare Contractor BI unit identifies and documents potential fraud and abuse and, when appropriate, refers such matters to the OIG.

Civil Monetary Penalties

Many violations of Medicare laws and regulations are subject to the imposition of Civil Monetary Penalties (CMP). Depending on the violation, the CMP amount may be up to $10,000 per violation and exclusion from the Medicare Program may be imposed. Some examples of violations for which CMPs may apply include:

- Violation of Medicare assignment provisions;
- Violation of the Medicare physician or supplier agreement;
- False or misleading information expected to influence a decision to discharge;
- Violation of an assignment requirement for certain diagnostic clinical laboratory tests and nurse-anesthetist services;
- A supplier who refuses to supply rental durable medical equipment supplies without charge after rental payments may no longer be made;
- Violations of the Anti-Kickback Statute, Stark Statue, and other fraud and abuse laws;
- Hospital unbundling of outpatient surgery costs; and
- Hospital and physician dumping of patients, either because they cannot pay or because of a lack of resources.

Denial or Revocation of Medicare Provider Number

CMS has the authority to deny an individual or entity's application for a Medicare PIN or to revoke a Medicare PIN if there is evidence of impropriety (e.g., previous convictions, falsifying information on the application, or State or Federal licensure or certification requirements are not met).

Suspension of Payments

CMS has the authority to suspend payment to individuals and entities when there is reliable information that:

- An overpayment exists;
- Fraud exists;
- Willful misrepresentation exists; or
- Payments to be made may not be correct.

During payment suspensions, claims that are submitted will be processed and individuals and entities will be notified about claim determinations. Actual payments due are withheld and may be used to recoup amounts that were overpaid. Individuals and entities may submit written rebuttals regarding why a suspension of payment should not be imposed.

Exclusion Authority

The OIG has the authority to exclude individuals and entities from participation in all Federal health care programs, including the Medicare Program. While the exclusion remains in effect, the individual or entity will not be able to claim payment for any items or services furnished, ordered, or prescribed in any capacity to program patients. In addition, excluded individuals are not eligible for

Federally-insured loans, Federally-funded research grants, and programs administered by other Federal agencies. All types of exclusions remain in effect until the individual or entity is eligible for and reinstated by the OIG. There are two types of exclusions:

1) Mandatory exclusions

Mandatory exclusions are imposed for a minimum statutory period of five years, although aggravating and mitigating factors may justify assessment of a lengthier exclusion. Exclusions are mandated for individuals and entities who:

- Have been convicted of any type of program-related violations;
- Have been convicted of patient abuse or neglect;
- Have felony convictions related to other health care programs; or
- Have felony convictions related to certain types of controlled substance violations.

2) Permissive exclusions

The OIG may impose permissive exclusions on individuals and entities who have misdemeanor convictions that are related to:

- Health care fraud;
- Obstruction of an investigation; and
- Certain types of controlled substance violations.

These permissive exclusions typically have a benchmark period duration of three years, although aggravating and mitigating factors may justify assessment of a lengthier exclusion.

Other permissive exclusions are based on determinations made by other agencies such as licensing boards, Federal or State health care programs, and/or recommendations from payer agencies. The period of exclusion in most of these actions varies and is subject to the discretion of the OIG.

Sanctioned and Reinstated Provider and Supplier Lists

There are two types of sanctioned and reinstated provider and supplier lists:

1) Office of Inspector General

The OIG List of Excluded Individuals/Entities (LEIE) contains the following information about individuals and entities that are currently excluded from participation in all Federal health care programs, including the Medicare Program:

- Name and address;
- Date of birth;
- Specialty;
- PIN(s);
- Unique Physician/Practitioner Identification Number; and
- The exclusion authority under which the exclusion was imposed.

The LEIE is available at *www.oig.hhs.gov/fraud/exclusions/listofexcluded.html* on the Web.

2) General Services Administration

The General Services Administration Excluded Parties List System contains debarment, exclusion, and suspension lists for all Federal agencies. The Excluded Parties List System can be found at *www.epls.gov* on the Web.

Incentive Reward Program

The Incentive Reward Program encourages the reporting of information with regard to individuals or entities that commit fraud or abuse that could result in sanctions under any Federal health care program. Medicare offers a monetary reward for information that leads to a minimum recovery of $100.00 of Medicare funds that were inappropriately obtained. Incentive rewards are 10 percent of the amount recovered or $1,000, whichever amount is lower.

Whistle Blower Provision

Under the Whistle Blower or *qui tam* provision of the False Claim Act, any individual who has knowledge of a false claim may file a civil suit on behalf of the U.S. government and may share a percentage of the recovery realized from a successful action.

How to Report Suspected Fraud or Abuse

To report suspected fraud or abuse, contact either:

- OIG National Hotline
  Telephone: (800) 447-8477
- Medicare Customer Service Center
  Telephone: (800) 633-4227

To find additional information about protecting the Medicare Trust Fund, see the Medicare Program Integrity Manual (Pub. 100-8) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.